Supreme Court, U. S.
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IN THE

Supreme Court of the United States

October Term, 1975

No. 75-1691

PAUL I. GUEST, President of Methodist Hospital; CHARLES H. FRENZEL, Executive Vice President of Mercy Catholic Medical Center; PHILIP J. SAWLINSKY, Manager of Patient Accounts of St. Joseph's Hospital, METHODIST HOSPITAL, and DELAWARE VALLEY HOSPITAL COUNCIL, on Behalf of Themselves and All Others Similarly Situated,

Appellants,

v

F. EMMET FITZPATRICK, District Attorney of Philadelphia, ROBERT P. KANE, Attorney General of the Commonwealth of Pennsylvania, Individually and in Their Official Capacities, THE INSURANCE DEPARTMENT OF THE COMMONWEALTH OF PENNSYLVANIA, and BLUE CROSS OF GREATER PHILADELPHIA,

Appellees.

JURISDICTIONAL STATEMENT.

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No.

PAUL I. GUEST, et al.

Appellants,

v.

F. EMMET FITZPATRICK, et al.

Appellees.

JURISDICTIONAL STATEMENT.

Appellants ask this Court to note jurisdiction to review the opinion and order of the three judge court entered in the above case on March 2, 1976.

CITATION TO OPINION BELOW.

The opinion and order of the lower court is not yet officially reported, but is appended hereto at pp. A5 to A33.

STATEMENT OF JURISDICTION.

Direct appeal to this Court is taken from the opinion and order of a three judge federal district court denying appellants' request upon summary judgment motion for a permanent injunction and granting appellees' cross-motion for summary judgment in an action pursuant to 28 U. S. C. §§ 2201 and 2202. Appellants were seeking to have declared unconstitutional and to have preliminarily and permanently enjoined the enforcement of the Pennsylvania Act of August 2, 1975, Act No. 94, 40 Pa. C. S. § 6124(c), a complete copy of which is attached hereto at pp. A1 to

A4. The district court entered its opinion and order on March 2, 1976,[1] and notice of this appeal, a copy of which is attached at p. A34, as well as of a protective appeal to the United States Court of Appeals for the Third Circuit, was filed in the United States District Court for the Eastern District of Pennsylvania on March 22, 1976.

This Court has jurisdiction pursuant to 28 U. S. C. § 1253 in that this appeal is taken from a final order denying permanent injunctive relief in a civil action required to be tried by a district court of three judges. **Florida Lime & Avocado Growers, Inc. v. Jacobsen,** 362 U. S. 73 (1960).

STATEMENT OF QUESTIONS PRESENTED.

1. Do not the Due Process and Contract Clauses prohibit retroactive state legislation which effects an impairment of substantive contract rights and a taking of property without just compensation, even though the state purports to have so legislated in accordance with its view of the public welfare?

2. Assuming arguendo that legislation retroactively extending and reinstating private contracts may be given the legal effect of prospective rate regulation, does not the Constitution protect a private, non-profit hospital from being compelled to render service at rates which do not permit it to recover its full historic costs of doing business?

3. Absent any state hearing procedure through which the hospitals could protest their being obliged to provide service at non-compensatory rates, was not the district court at least obliged to provide the hospitals a hearing on their allegation that the rates under which Act 94 compels them to provide service are confiscatory?

1. Although the order is dated February 27, 1976, it was not entered until March 2, 1976. The earlier date is used in the notice of appeal to avoid any question with respect to its timeliness.

STATEMENT OF THE CASE.

Procedural History.

This is an appeal from the decision of a three judge court upholding the constitutionality of the Pennsylvania Act of August 2, 1975, Act No. 94. That Act, which amends Section 6124 of Title 40 of the Pennsylvania Consolidated Statutes, provides that no contract between a hospital plan corporation, such as defendant Blue Cross of Greater Philadelphia ("Blue Cross"), and an eligible hospital may be terminated except upon ninety days notice and subject to prior approval by the Insurance Department of the Commonwealth of Pennsylvania. When the hospital or hospitals involved have more than five percent of the beds in an area served by a hospital plan corporation, as do appellants here, the Insurance Department is authorized to suspend further the termination of such contract for a period of ten additional months, during which time the contract sought to be terminated is to continue in full force and effect while the Insurance Department holds hearings and may supervise contract negotiations.

It is explicitly provided that the Act shall apply retroactively to the termination of any covered contract "under which subscribers [of the hospital plan corporation] received prepaid benefits on or after June 30, 1974 . . . [which] contracts, if terminated, shall be reinstated as of their original termination and may be terminated hereafter only pursuant to the provisions of the Act." Section 2(2), 40 Pa. C. S. § 6124(c)(2).

The Act provides at Section 1(c)(5) that if a new contract is successfully negotiated during the statutory extension period "the terms and conditions of any new contract shall be retroactive to the date of expiration of the contract previously in effect between the parties."

There is no provision for any adjustment of payment made under the contract during the thirteen month statutory period of suspended termination if a new agreement is not negotiated.

On September 12, 1975, an Amended Complaint[2] was filed on behalf of a class comprised of all hospitals which were or are parties to contracts covered by Act 94 and all executive officers, administrators and employees of those hospitals who would be exposed to criminal prosecution under Section 6105 of Title 40 for violations of the Act, seeking to have Act 94 declared unconstitutional and its enforcement against plaintiffs preliminarily and permanently enjoined. The case was assigned to a there judge panel in accordance with 28 U. S. C. §§ 2281 and 2284, and was heard by agreement of the parties upon oral argument on October 14, 1975, on cross-motions for summary judgment and supporting affidavits of fact and memoranda of law.

On March 2, 1976, a final opinion and order of the court was entered by District Judge Charles R. Weiner, joined by Circuit Judge Francis L. Van Dusen, denying appellants' motion for summary judgment and granting appellees' motion for summary judgment upon the request for permanent injunctive relief (see District Court Opinion at A6, n. 1). District Judge Alfred L. Luongo dissenting, would have held Act 94 unconstitutional [illegible] "retrospective effect" or at the least would have required that there be a trial of the disputed issues of fact. Dissenting Opinion at A26, A29, n. 1. Appellant filed notice of this appeal and a protective appeal to the United States Court of Appeals for the Third Circuit on March 22, 1976.[3]

2. The original complaint was filed on August 11, 1975, but was amended in accordance with a subsequent stipulation of the parties.

3. A separate notice of appeal to this Court was filed March 24, 1976, by counsel for Williamsport Hospital and the Hospital Association of Pennsylvania, plaintiffs-intervenors below.

Operative Facts.

Defendant Blue Cross is a hospital plan corporation within the meaning of the relevant statute, 40 Pa. C. S. §§ 6101 *et seq.*, having received a Certificate of Authority under Section 6102 to establish, maintain and operate "[a] plan whereby for prepayment, periodical or lump sum payment hospitalization or related health benefits may be provided to subscribers to such plan." 40 Pa. C. S. § 6101.

Of course, Blue Cross does not itself provide "hospitalization or related health benefits." Rather, it is authorized to contract with hospitals which provide such services to Blue Cross subscribers to accept reimbursement directly from Blue Cross in accordance with a negotiated payment schedule. Any hospital incorporated under the laws of Pennsylvania may enter such a contract with Blue Cross, 40 Pa. C. S. § 6121, thereby becoming a so-called "member" hospital. On the other hand, many hospitals have chosen in the past not to become members of a hospital plan corporation.

However, at least until the passage of Act 94, no hospital could be required to negotiate a contract with a hospital plan corporation or otherwise to accept payment from a third party payor of less than its normal charges. Therefore, when a Blue Cross subscriber receives services from a "non-member" hospital, the hospital retains its common law right to collect payment from the subscriber-patient who, in turn, can collect from Blue Cross, but only to the extent of the non-member benefits available under the terms of the subscriber contract.

The public emergency claimed by the legislature and the court below to justify passage of Act 94 was the termination, more than a year before passage of the Act, of a contract negotiated by defendant Blue Cross and

plaintiff-intervenor Delaware Valley Hospital Counsel ("DVHC"), and the consequent loss of "member" status by the 37 hospitals represented in contract negotiations by DVHC (the "Delaware Valley Hospitals").[4] In fact, the contract, which was entered into on July 1, 1971, and was terminable upon 90 days notice, should have expired by its terms on July 1, 1972; however, it was continued by a series of interim agreements until March 31, 1974, when, after more than two years of unsuccessful efforts, further negotiation seemed futile.[5]

4. Pertinent portions of this contract as well as the various addenda which together were referred to below as the "Delaware Valley Agreement," are attached as Exhibit B to the Memorandum of Plaintiffs and Plaintiffs-Intervenors in Support of Motion for Summary Judgment.

5. The two year contract provided for a ceiling limitation (over the prior year's costs) on Blue Cross payments for the first contract year only; it provided further that unless new payment terms could be negotiated six months prior to the end of the first year, the contract would terminate as of July 1, 1972. However, on July 1, 1972, when federal price controls were in effect under the Economic Stabilization Act, the parties agreed that the contract would continue and the hospitals would be reimbursed their allowable costs as approved by Blue Cross for the prior year plus only that increase permitted by the applicable federal control ceilings. (This is the so-called 1972 Amendment.)

The parties still had not been able to negotiate a new contract when the Hospital Agreement, as amended, terminated on July 1, 1973. They continued to negotiate, however, and in February, 1974, agreed to a "Summary of Principles" retroactive to the July 1 termination date as the basis for an ongoing contractual relationship. The Summary of Principles basically continued in effect with some minor modifications until March 31, 1974, the previous Hospital Agreement as modified by the Amendment of July 1, 1972. Thus, through March 31, 1974, Blue Cross continued to reimburse plaintiff Delaware Valley Hospitals in accordance with the ceilings imposed by federal economic controls.

When the parties failed to reach agreement on a new contract by March 31, 1974, the Agreement, as modified and extended by the Summary of Principles, terminated and a ninety-one day "continuation" period commenced. By agreement this "continuation" period was extended for an additional 31 days until July 31, 1974. Finally, on August 1, 1974, the hospitals rejected Blue Cross' attempt to extend the agreement unilaterally to August 15, 1974.

The simplest explanation for the failure of the contract negotiations is that Blue Cross payments under the Delaware Valley Agreement simply did not cover the hospitals' true allocated costs of providing service to Blue Cross subscribers. Rather the Agreement was based on a principle under which the hospitals were reimbursed the identifiable cost of services rendered individual Blue Cross subscribers, but no part of the expenses incurred by the hospitals in providing care to indigents, in writing off uncollectable amounts other than those of Blue Cross subscribers during the period of their coverage, in providing charity allowances, in undertaking certain educational and research activities, and in providing for future growth needs.

These items of hospital expense excluded from the Blue Cross reimbursement formula are not identified to any individual patient, but are part of the hospitals' total cost of providing service. Normally, they are billed accordingly on a pro-rata basis to all private paying patients. Thus, Blue Cross' refusal to recognize these costs results in a loss to the hospital of the difference between the amount of charges properly allocable to Blue Cross subscriber-patients and the amount of reimbursement actually paid by Blue Cross.

As developed in appellants' affidavits, there was no hospital which did not suffer such a loss under the Delaware Valley Agreement, though the amount of loss varied from a low of $50,000 per year in the case of Jeanes Hospital through $203,400 reported by Presbyterian-University of Pennsylvania Medical Center to more than $655,000 reported by Mercy Catholic Medical Center for fiscal year 1974. See Affidavit of Edward J. Armstrong, paragraph 10, and Supplemental Affidavit of Joseph A. Williamson, paragraph 6.

For non-profit hospitals, such as appellants, the amount of these Blue Cross underpayments necessarily translates into a net operating loss.[6]

In order to make up for the deficiencies in the Blue Cross cost reimbursement formula, the Delaware Valley Hospitals had insisted that any new contract must include some additional payment which would permit the hospitals to recover their operating costs. Such a so-called "plus factor" is common in Blue Cross contracts and, in fact, had been included in a prior agreement between Blue Cross and DVHC dated July 1, 1967. Ultimately the Insurance Department, itself, recommended the inclusion of a plus

6. As is documented in the affidavits relied on by appellants below, there are only a limited number of sources from which a non-profit hospital may recover the operating expenses which Blue Cross refuses to pay. Some is surcharged to those private patients who are self-insured or covered by commercial insurers. While in most cases it is not possible to impose the entire burden on this relatively small segment of the patient population, the need to reduce losses by surcharging private paying patients has resulted in situations where private insurers may pay full charges as much as 40% more than those paid by Blue Cross for comparable services rendered its subscribers. Williamson Affidavit, paragraph 7.

To the extent that the pool of private paying patients is too small to make up the total deficiencies in Blue Cross payments (and, as the burden of these deficiencies on the private paying patients becomes greater, more members of this group who are able to do so are under pressure to become Blue Cross subscribers, thus, shrinking the size of the pool and increasing accordingly the burden on each member in a self-accelerating process), the hospitals must reduce their net operating loss from non-operating income sources. Thus, they use unrestricted endowment fund income where available and, in at least one case, endowment fund principal to the extent permitted by law. Williamson Affidavit, paragraphs 8 and 9. The most common device, however, is for the hospitals to meet their current operating needs by utilizing that portion of Blue Cross payments which is supposed to be funded for a depreciation reserve. In some cases, it is necessary for a hospital to use up virtually all of its depreciation reserve to meet its daily operating needs. In this way, the hospital remains solvent by pushing forward its bottom line operating loss to some future time when it will be unable to replace fully depreciated facilities and equipment. Williamson Affidavit, paragraph 10.

factor as a basis for negotiations between Blue Cross and DVHC; however, while negotiations proceeded for a time on the assumption that a plus factor would be included, Blue Cross finally refused to offer DVHC anything beyond the direct cost reimbursement formula. Affidavit of Paul I. Guest, paragraphs 2-5.[7]

When the extended 1971-72 agreement between Blue Cross and the hospitals expired, the hospitals did not have or assert a right to collect full charges from Blue Cross subscribers immediately upon termination of the Delaware Valley Agreement. Rather, on August 15, 1974, the contractual 12 month run-out period commenced with the effect that following termination of the hospital agreement as a general contract, it continued in force on an individual basis for the term of any subscriber contracts entered while it was in general effect.[8]

7. As a matter of fact, within a few days following passage of Act 94 the DVHC negotiators and the attorney for Blue Cross, through the efforts of and in the presence of Mr. Mongelli, Deputy Insurance Commissioner, reached complete agreement on a package settlement which was acceptable to the Insurance Department and the negotiators. The hospitals accepted the proposed contract; however, the Blue Cross Board of Directors rejected it. That contract, approved by the defendant Insurance Department, included a plus factor of 4% per year for each of three years. See Guest Affidavit, paragraphs 7-10; See also Williamson Affidavit, paragraph 15.

8. The Delaware Valley Hospital Agreement provides as follows at Section 27:

Obligations after Termination

"In the event this Agreement terminates for any of the reasons set forth herein, the Provider, if paid in accordance with Section 2 of this Agreement, shall continue to furnish services and facilities in accordance with the terms hereof to all persons who were Subscribers at the time of their admission to the Provider, and (a) who were admitted to the Provider or treated as outpatients during the ninety day period following the date of such termination; or (b) who were inpatients on the date of such termination; or (c) who were admitted to the Provider *during the unexpired portion of their agreement year*

It was precisely to insure that no Blue Cross subscriber would be deprived of any prepaid benefits that the run-out provisions obligated Blue Cross to pay and the hospitals to accept full payment upon member terms for services rendered subscribers during the yet unexpired term of their individual subscriber contracts. Accordingly, it was only after a subscriber's individual contract expired upon reaching its anniversary date that the subscriber became liable to the hospital as any other paying patient for the total allocated costs of services received and Blue Cross became obligated under any subsequent renewal contract with that subscriber only to the extent of non-member benefits.

The run-out period would have ended for the last subscriber contracts on August 15, 1975, but for the passage of Act 94 which was signed effective immediately on August 2, 1975, at a time when fewer than 5% of all Blue Cross subscribers could still demand treatment from DVHC hospitals at "member" rates. In other words, the impact of Act 94 was to deprive these hospitals of an already vested right to recover from 95% of all Blue Cross subscribers, as they would from any other private paying patients, the full allocated costs of services provided. Moreover, since rights against many of these subscribers had already been implemented, a further effect of Act 94 noted by the majority below is that "[t]he hospitals are now faced with the prospect of repaying those subscribers and receiving only cost reimbursement from Blue Cross under the 1971 Contract." District Court Opinion at A12.

(Footnote 8. cont'd)
current at the termination, i.e., the date 90 days after the delivery of notice of termination under subsection 26.1 or the similar date under other sections." (Emphasis added.)

THE ISSUES ARE SUBSTANTIAL.

1. The majority below, held that "[t]he public interest underlying Act No. 94 clearly justifies any incursions it makes into the contract rights of the parties here." District Court Opinion at A15. Judge Luongo, dissenting, did not dispute the state's power to act in the public welfare; he recognized, however, that the state may not effect an impairment of private contract rights which is so substantial as to constitute a taking of property without just compensation "[n]o matter how great the public need." Dissenting opinion at A29.

This Court's decisions in the mortgage moratorium cases of the early 1930's clearly support Judge Luongo's conclusion that regardless of public need, a state is constitutionally prohibited from enacting legislation which retrospectively alters substantial contract rights, and not alone the remedy for enforcement of those rights.

Thus, in **Louisville Joint Stock Land Bank v. Radford,** 295 U. S. 555 (1935), the Court struck down the Frazier-Lemke Act, a federal law which would permit mortgagors to redeem property at its appraised value without reference to the actual debt outstanding, on the grounds that the forced surrender of property so long as any part of the debt secured thereby remained unpaid effected a taking of property without just compensation. It held such a taking to be constitutionally prohibited no matter how great the public need. *Id.* at 602.

The Court distinguished its approval of other moratorium measures which resulted essentially in delaying mortgagees' remedies as resting on the "assumption that no substantive right of the mortgagee was impaired, since payment in full of the debt with interest would fully compensate him." *Id.* at 581.

Accordingly, while the Court had approved in **Home Building & Loan Association v. Blaisdell,** 290 U. S. 398, 425 (1934), a Minnesota statute which extended the period of redemption but otherwise "[did] not impair the integrity of the mortgage indebtedness," it struck down the following year in **W. B. Worthen Co. v. Kavanaugh,** 295 U. S. 56 (1935), an Arkansas statute which also extended the redemption period, but permitted the mortgagor to retain possession without payment of interest, taxes, or rent. **Blaisdell** was distinguished on the grounds that those restrictive conditions in the Minnesota statute which safeguarded the substantive interest of the mortgagee in protecting his investment were absent in the **Worthen** case. *Id.* at 63.

In **Fornaris v. Ridge Tool Co.,** 423 F. 2d 563 (1st Cir. 1970), *rev'd. on other grounds* 400 U. S. 41 (1971), the case which Judge Luongo found "most nearly on point" (Dissenting Opinion at A32), the Court of Appeals for the First Circuit recast the traditional distinction between substantive and procedural rights in terms of the effective deprivation of property and went on to hold that, the police power notwithstanding, ". . . only minor infringement of established contractual rights may be effected without just compensation." *Id.* at 567.

The court then held unconstitutional as applied to contracts entered before its passage, a Puerto Rican law which prohibited a manufacturer from terminating any dealership contract unless justified by a substantial failure of performance by the dealer. The court stated, pp. 567-68:

> ". . . No amount of research by parties or amici has discovered a case suggesting that to convert a contractual relationship terminable by either party without cause into one which, short of breach by the other party, can be terminated by one of the parties only by making substantial payments and without protection for its economic interests, is not a change of great magnitude."[9]

Accord, **Superior Motors, Inc. v. Winnebago Industries, Inc.,** 359 F. Supp. 773 (D. S. C. 1973); **Globe Liquor Co. v. Four Roses Distillers Co.,** 281 A. 2d 19 (Del. 1971), *cert. denied* 404 U. S. 873 (1971).

Although plainly there will be cases where the distinction between substance and procedure is blurred or where the degree of impairment is not clearly of an unconstitutional magnitude,[10] this is hardly such a close case.

Even where the effect of Act 94 is merely to continue for ten additional months an existing contract otherwise terminable upon ninety days notice, its impact is not, as

9. This Court reversed the decision of the First Circuit at 400 U. S. 41 (1971), on the grounds that the state courts should be given an opportunity to construe the retroactive impact of the statute in a manner which might avoid the constitutional question. *Compare* **AFA Distributing Co., Inc. v. Pearl Brewing Co.,** 470 F. 2d 1210 (4th Cir. 1973) (reversing a lower court decision holding a similar statute inapplicable to existing contracts on the grounds that the state courts might construe the statute to apply retroactively such that the resulting Contract Clause issue would have to be resolved); and cf. **Mariniello v. Shell Oil Co.,** 511 F. 2d 853 (3d Cir. 1975).

10. The majority below, for example, relied on this Court's decision in **Day-Brite Lighting, Inc. v. Missouri,** 342 U. S. 421 (1952), which held that an employer may not penalize or influence an employee in the exercise of franchise rights in any way, including the docking of wages for time taken from work in order to vote.

Apart from the fact that the public interest in **Day-Brite** was the protection of fundamental rights guaranteed by the Constitution, the case is clearly distinguishable in terms of the degree of private burden involved. As noted by Judge Luongo, the financial burden upon "the net return" from a business enterprise which this Court found justifiable in **Day-Brite,** ". . . is a far cry from the plight of these non-profit hospitals which contend they are being forced to operate at inadequate and confiscatory levels of reimbursement." Dissenting opinion at A31.

the majority claims, merely to delay the hospitals' right to terminate "without penalty." District Court Opinion at A16. Rather, the hospitals are clearly penalized and deprived of property to the extent of the difference between what they otherwise would be entitled to charge for services rendered Blue Cross subscribers during that additional ten-month period and the amount recoverable for those services under the extended contract.

Nor can this loss ever be recouped in the event the hospital does not choose to negotiate a new contract with Blue Cross, since Act 94 provides absolutely no mechanism for adjusting the rate of payment for the statutory extension period unless a new contract is signed.[11]

The extent of the deprivation of property, as well as the enormity of the conractual impairment imposed by Act 94, is dramatized in the case of the Delaware Valley Hospitals whose contract with Blue Cross terminated more than sixteen months prior to the passage of Act 94. After negotiating unsuccessfully for two years, these hospitals had felt impelled to get out from under a losing contract, only to have that same contract reimposed upon them sixteen months later by legislative fiat. Moreover, as the majority itself recognized, Act 94 imposed upon these hospitals the further loss represented by the duty of "repaying those subscribers [previously billed directly for full charges] and recovering only cost reimbursement from Blue Cross under the 1971 Contract." District Court Opinion at A12.

11. At paragraph 58 of the affidavit submitted by Blue Cross, its president Bruce Taylor stated that even if no new contract is signed the hospitals will still receive full reasonable costs for services rendered subscribers during the "cooling off" period "determined by a Court, if necessary." In fact, the court below refused to make such a determination. *See* District Court Opinion at A17. However, in any event, the confiscatory effect of Act 94 must be determined apart from the availability of collateral actions for relief in federal court.

Thus, the effect of Act 94 on the Delaware Valley Hospitals is to require them to provide service for a total of 29 months, almost two and a half years, at rates which do not permit them to recover the full costs of providing such service, and with no way of recouping their losses should they resist the legislature's attempt to coerce them into negotiating a new contract with Blue Cross.

Moreover, the effect of Act 94 on the hospitals is even more outrageous when "viewed in the light of the reasonable expectations of the parties when the contract was entered into." **Fornaris,** *supra,* 423 F. 2d at 567.

In the Declaration of Necessity, Act 94 is alleged to be responsive to the expectations of Blue Cross subscribers. However, if subscribers had any legitimate expectations,[12] they derived from their subscriber contracts with Blue Cross and their reliance on Blue Cross' implicit promise that it would enroll a substantial number of hospitals as members. Moreover, it is Blue Cross which has reaped a financial windfall when, because of its failure to negotiate member hospital agreements, it became liable to its subscribers only to the extent of the normally much smaller non-member benefits.

Thus, while Blue Cross might very well have expectations that it would be called upon to cover its subscribers' costs of hospitalization in the event it was unable to negotiate member hospital agreements, the hospitals—which have never solicited or contracted with Blue Cross subscribers and have received no consideration from them—

12. As was stressed repeatedly below, implementation of the run out provisions insured that no subscriber was deprived of prepaid benefits. Moreover, any subscriber who renewed Blue Cross coverage after July 31, 1974, did so with full knowledge that Blue Cross would pay only non-member benefits in connection with claims for services provided by the Delaware Valley Hospitals, and did so in preference to purchasing commercial insurance which has been available at all times and provides indemnity coverage for full hospital charges.

certainly can not be charged with any *reasonable* expectation that if they refused to accept a contract on Blue Cross' terms, they would have to accept legislative imposition of these very same terms.

Particularly in light of the parties' reasonable expectations, then, it cannot be seriously doubted that, at least in its retrospective application to terminated and pre-existing contracts, Act 94 effects a substantial impairment of contract and an uncompensated taking of property condemned by both the Contract and Due Process Clauses of our Constitution.

While the Court need not reach this issue if it finds Act 94 repugnant to the Constitution only in its retrospective effect, appellants reserve the right to argue, either on remand to the district court or in a future state court proceeding, that Act 94 is not severable and must fall in its entirety.[13]

2. Appellees argued below that Act 94 is no more than a piece of rate regulation. Assuming *arguendo* that this is true, though it clearly is not (*see* Dissenting Opinion at A31), Act 94 must fall still as an unconstitutional taking of property without just compensation.

Appellants' affidavits—which the court below was required to accept as true upon appellees' motion for summary judgment—establish that the contracts extended and reinstated by Act 94 are confiscatory contracts under which the hospitals are unable to recover from Blue Cross the share of the hospitals' true costs of doing business properly allocable to services rendered Blue Cross sub-

13. Appellants argued below that the retrospective and prospective applications of Act 94 are so closely intertwined as a matter of both legislative intent and statutory construction that severance would be impossible. Therefore, the Act being clearly unconstitutional in its retrospective application, the entire statute must fall. *See, e.g.*, **Sloan v. Lemon, 413 U. S. 825 (1973); Saulsbury v. Bethlehem Steel Co., 413 Pa. 316 (1964).**

scribers. Since it is clear that even public utilities may not be compelled to provide service at less than a fair rate of return, **Denver Union Stock Yard Co. v. United States, 304 U. S. 470 (1938); D. C. Transit System, Inc. v. Washington Metropolitan Area Transit Commission, 466 F. 2d 394 (D. C. Cir.), *cert. denied* 409 U. S. 1086 (1972)**, then certainly private hospitals, and particularly non-profit hospitals, may not be forced by the state to provide service under contracts which do not reimburse them their full allocated costs of providing that service. Moreover, it is clear that under general public utility law, the courts have recognized as operating expenses properly considered in setting reasonable rates such cost of doing business as uncollectible customer accounts. *See e.g.*, **Solar Electronic Co. v. Pa. P. U. C., 137 Pa. Superior Ct. 325, 379 (1939); Chambersberg Gas Co. v. P. U. C., 116 Pa. Superior Court 196, 224-25 (1935).**

The majority below met this contention with three different arguments, none of which is responsive to the uncontested fact that appellant hospitals cannot recover under the extended and reinstated contracts with Blue Cross that proportionate share of their total cost of doing business which they must recover from or on behalf of every private paying patient if they are to remain in business.

(a) The first grounds upon which the majority responded to appellants' contention that the cost reimbursement formula imposed upon them by Act 94 is confiscatory, was that "[t]he validity of such clauses in Blue Cross-hospital contracts has already been upheld." District Court Opinion at A16. The majority then claimed to see nothing in the instant challenge to distinguish it from **Travelers Insurance Co. v. Blue Cross of Western Pennsylvania, 481 F. 2d 80 (3d Cir. 1973)**, a case involving

claims by a private insurer that contract arrangements between Blue Cross of Western Pennsylvania and various hospitals violated the antitrust laws.

It does not require elaborate argument to expose the flaw in the majority's use of the **Travelers'** case. It suffices to say that the Court of Appeals' holding in **Travelers** that ". . . the economic inducements which made the Blue Cross contract acceptable to hospitals did not amount to 'coersion,'" so as to constitute unlawful conduct under the antitrust laws, 481 F. 2d at 84, does not speak to the issue of whether the legislature may impose those same contract terms upon hospitals by statute without running afoul of the Constitution.

In fact, if **Travelers** has any meaning here at all, it is that whether or not a private party voluntarily chooses to enter a contractual relationship has nothing whatever to do with the objective fairness of the contractual terms. Thus, the fact that appellant hospitals voluntarily entered the non-compensatory Delaware Valley Agreement in 1971 is irrelevant to the power of the Pennsylvania legislature to impose the same agreement on appellant hospitals in 1976.

(b) A second ground advanced by the majority in support of its granting appellees' motion for summary judgment on the confiscation issue is that "[t]he affidavits of plaintiff are far too generalized to justify the grant of summary judgment in their favor." District Court Opinion at A20.

At the very least, one would agree with Judge Luongo that if the affidavits are not conclusive, they at least raise material issues of fact requiring trial. Dissenting Opinion at A29, n. 1. The law is quite clear in this respect that the filing of cross-motions for summary judgment in no way alters the burden upon each party to establish its entitlement to judgment as a matter of law upon genuinely undisputed facts. **Rhoads v. McFerron,** 517 F. 2d 66 (2d Cir. 1975); **Weiss v. Kay Jewelry Stores, Inc.,** 470 F. 2d 1259 (D. C. Cir. 1972); **Rains v. Cascade Industries, Inc.,** 402 F. 2d 241 (3d Cir. 1968).

More important, the majority below did not explain why, simply because Blue Cross does not require the hospitals to undertake those expenses such as indigent patient care for which it refuses to pay, "plaintiffs have failed to show that the expenses incurred by plaintiffs under Act No. 94 are the cause of the anticipated confiscatory effect of continuing operations under the Delaware Valley Agreement." District Court Opinion at A21. This is to suggest that the hospitals have not been harmed because if they simply did not provide care to indigents or others whose ability to pay was in question, including Blue Cross subscribers once their coverage had lapsed,[14] and if they otherwise permitted Blue Cross to determine the extent of their community responsibility, then the Blue Cross reimbursement formula imposed upon the hospitals by virtue of Act No. 94 would be fully compensatory. The court accepted, in other words, that Blue Cross somehow has the right to determine the proper expenses of running a hospital.

The majority, thus, refused to recognize that the hospitals have any obligation which must be taken into account in mandating charges to provide indigent patient care or other forms of community service. This position is

14. A large proportion of the hospitals' bad debts result from the unpaid bills of patients who enter the facilities as Blue Cross subscribers and then have their coverage lapse during the course of their hospitalization. The Blue Cross reimbursement formula does not recognize or reimburse any portion of these uncollectible charges. Williamson Affidavit, paragraph 4. Thus, at the same time that Blue Cross refuses to assume any fiscal responsibility for the hospitals' costs of treating indigents, it imposes upon others the responsibility for the hospitals' costs of treating patients who initially demanded services as Blue Cross subscribers.

ironic in view of the fact that the majority found Act 94 justified in the first instance because hospitals are institutions affected with the public interest and the presumed unavailability of hospital services is a crisis which would justify otherwise unconstitutional legislative intervention. *See e.g.*, District Court Opinion at A14-A15.

It also ignores the fact, which appellants would have thought to be a subject of judicial notice, that from its pre-Christian origins until the present day, the hospital has developed as a social and charitable institution which has never existed as the purely rational economical entity the lower court would have it be. *See generally* E. Churchill, "The Development of the Hospital," in THE HOSPITAL IN CONTEMPORARY SOCIETY (N. Faxon, *ed.* 1946).

Moreover, if the European hospital was historically a charitable institution endowed by the rich for the use of the poor, *See generally* H. Burdett, HOSPITALS AND ASYLUMS OF THE WORLD (1893) Vol. III; Churchill, *supra*, the American hospital developed from the start as a humanitarian and truly social institution supported by all classes of society for the benefit of society as a whole. American hospitals tempered the charitable ideal with the principle that it was important to the patients' self respect that they pay whatever they were able to. Accordingly, hospital charges in this country have always been graded to the individual patient's income level. M. Risley, THE HOUSE OF HEALING (1961) at p. 226.

It is anathema to this ideal and to the development of the hospital generally as a social institution, for Blue Cross to suggest that it can isolate the incremental cost of services to its subscribers from the overall costs to the hospital of discharging its historic duty of service to the community.

(c) Ultimately, the majority contended that whether or not the contractual rate of payment imposed by Act 94 is

confiscatory is a matter for "the legislative process as distinguished from judicial inquiry," which matter, it determined, had been delegated by the legislature under Act 94 itself to be resolved by the Insurance Department. District Court Opinion at A17.

This argument not only fails to comprehend the role assigned the Insurance Department under Act 94, but misconceives the role of the federal judiciary under the Constitution of the United States.

It is plain that the Insurance Department has no duty under Act 94 to assure that payment under the extended or reinstated contracts is reasonable. More important, it has no power to order any retroactive adjustment of payments except insofar as the Act itself provides that *if* a new contract is negotiated, its terms shall apply retroactively to the date of termination of the prior agreement. Thus, even if the Insurance Commissioner did find the contracts imposed by Act 94 to be confiscatory—and his recommendation of a "plus factor" in the earlier negotiations suggests that he did not find to the contrary—the most he could do would be to cut short the period of time for which he has authority under Act 94 to suspend the hospitals' right of termination.

In other words, the Insurance Department has power under Act 94 to exascerbate the confiscatory impact of the imposed contracts, but no power to relieve it.

Under these circumstances, the court below plainly was obligated to hear and resolve appellants' claim that the rate of payment effectively imposed upon them by Act 94 is confiscatory and constitutes an uncompensated taking of property prohibited by the United States Constitution.

3. Many of the most serious defects in the majority's legal reasoning may be traced to a single factual error, *i.e.*, that appellant hospitals are regulated entities. While the

majority was not willing to endorse in so many words Blue Cross' argument that Act 94 is simply a piece of rate regulation, it did accept all the erroneous factual premises necessary to that theory.

It is simply *not* true that hospitals entering contracts with Blue Cross must be approved by the Department of Public Welfare (*see* District Court Opinion at A8, A21-A22).[15] Nor is it true that by entering such a contract, the hospitals become subject to regulation by the Insurance Department (*see* District Court Opinion at A21, A22). Rather 40 Pa. C. S. § 6124(a) provides only that the Insurance Department shall have authority to approve certain transactions of hospital plan corporations authorized under that chapter, which transactions include contracts negotiated by hospital plan corporations with hospitals. Thus, it is only to the extent that a hospital joins in the submission of such a contract for the approval of the Insurance Department, that it is subject to either regulation or the jurisdiction of the Insurance Department or any other regulatory or administrative body.

Nonetheless, the majority below distinguished the decision in **Fornaris v. Ridge Tool Co.**, *supra*, on the grounds that "their [the hospitals] expectations as a regulated industry are different from those of the commercial manufacturers in **Fornaris**." District Court Opinion at A16. Moreover, it analogized that effect of Act 94 which requires that appellants refund subscriber payments lawfully due

15. 40 Pa. C. S. § 6121 contains the following definition of hospitals "eligible" to enter contracts with Blue Cross:

§ 6121. Eligible hospitals

Any hospital plan corporation may enter into contracts for the rendering of hospitalization to any of its subscribers only with hospitals operated by the Commonwealth, or its agencies, or by political subdivisions, or by corporations organized under the laws of this Commonwealth for hospital purposes, or with such other hospitals as are approved by the Department of Public Welfare.

and remitted prior to the enactment of Act 94 to "remedial measures in other regulatory statutes" as, for example, when carriers are required to "refund, with interest, increased rates found to be not justified." District Court Opinion at p. A19, n. 12 and accompanying text.

What is most bizarre about this theory—beside its irrelevance to the facts—is that if the hospitals were regulated in fact, they would have been afforded those fundamentals of due process—both procedural and substantive—which they have been denied here.

Implicit in the assumption of regulation is the belief that there is some regulatory body required to take into consideration the interests of the regulated party and from which that party may seek relief from an onerous exactment. Thus, for example, the majority assumed the Insurance Department was authorized to consider and adjust the adequacy of payment under the reinstated contracts. However, as noted above, the Insurance Department lacks the power to effect any change in the contract rates. Nor is there any other regulatory agency in any way charged with overseeing appellants' interests.

Moreover, there is every reason to believe, as the dissent suggests, that the legislature, itself, never considered the hospitals' interests, but evidenced in Act 94 "an unfortunately hasty reaction" to the complex problem spawned by the Blue Cross contract dispute. Dissenting Opinion at A33.[16]

Appellants here have no recourse but to the courts to draw the constitutional limits on the extent to which private parties may be required to bear the burden of the presumed

16. In contrast, this Court relied upon the legislature's "conscientious effort and thoroughness" in studying the factual circumstances which led to the purely prospective regulation upheld in **Nebbia v. New York**, 291 U. S. 502, 516 (1934), a case cited repeatedly by the majority below.

public welfare. For the majority then to declare, in effect, that the Constitution bows to the judgment of the Pennsylvania legislature even when, as here, it allows itself to be manipulated by a private interest, constitutes not only a radical departure from established precedent, but an abdication of judicial responsibility which this Court ought to note jurisdiction to rectify.

CONCLUSION.

Wherefore, for all of the above reasons, it is respectfully submitted that the Court ought to note probable jurisdiction to review and reverse the decision from which this appeal is taken.

Respectfully submitted,

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APPENDIX A.

STATUTE INVOLVED.

Session of 1975

Nonprofit Hospital Insurance Plans

Act No. 94

H. B. NO. 1347

An Act amending Title 40 (Insurance) of the Pennsylvania Consolidated Statutes, adding provisions relating to contractual relationships between hospital plan corporations and hospitals, providing for the maintenance of such contractual relationship during disputes, authorizing the Insurance Department to take certain action with respect thereto, and providing for the temporary restoration of certain lapsed contractual relationships.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1.

Section 6124 of Title 40, act of November 25, 1970 (P. L. 707, No. 230), known as the Pennsylvania Consolidated Statutes, added November 15, 1972 (P. L. 1063, No. 271), is amended by adding a subsection to read:
§ 6124. Rates and contracts [98]

• • •

98. 40 Pa. C. S. A. § 6124 subsec. (c).

(c) Maintenance of contractual relationships.—

(1) Declaration of necessity.—It is hereby found that many subscribers to nonprofit hospital plans make payments over long periods of time prior to becoming entitled to benefits under such a plan and that it is important in the public interest that the reasonable expectations of such subscribers as to coverage should be fulfilled if possible. It is hereby declared to be essential for the maintenance of the health of the residents of this Commonwealth that subscribers to nonprofit hospital plans be assured receipt of the hospitalization and related health benefits prepaid by them through payment of the rates approved under this chapter and charged by a hospital plan corporation and that to accomplish this essential purpose termination of contracts between hospital plan corporations and hospitals entered into pursuant to section 6121 (relating to eligible hospitals) and this section be subject to prior approval by the department as provided in this subsection.

(2) Notification period.—No contract between a hospital plan corporation and any hospital providing for the rendering of hospitalization to subscribers to the hospital plan shall be terminated unless the party seeking such termination gives 90 days advance written notice to the other party to the contract and to the department of the proposed termination.

(3) Hearing period.—Whenever a termination subject to paragraph (2) involves contracts with hospitals having more than 5% of the beds in the area served by a hospital plan corporation, the department shall hold public hearings on at least 15 days notice for the purpose of investigating the reasons for the

termination. Pending completion of said investigation by the department, termination of the hospital contracts shall be suspended for a period not to exceed six months from the expiration of the period provided for in paragraph (2). All terms and conditions of the contract between the hospital plan corporation and the hospital or hospitals shall continue in full force and effect during said investigation by the department. Based on the record made during the hearings, the department shall make specific findings as to the facts of the dispute and shall either approve termination of the contracts or recommend such terms for continuation of the contract as are in the public interest, based upon the facts, the right of a hospital to be paid its costs for hospitalization services to subscribers and the need of subscribers for efficient, reliable hospitalization at a reasonable cost.

(4) Negotiation period.—If the department recommends terms for continuation of the contract, the hospital plan corporation and the hospitals involved shall renew their negotiations in order to determine whether a new agreement can be reached substantially on the basis of the terms for continuation recommended by the department and pending such negotiations, the termination of the hospital contracts shall be suspended for a further period not to exceed 90 days from the date of the decision of the department. If the hospital plan corporation and the hospitals are unable to consummate a new contract within said further period of 90 days, they shall so advise the department. The department shall in that event approve termination of the contracts effective at the end of a further period of 30 days and shall prescribe the form and extent of notice which the hospital plan

corporation shall use in advising its subscribers that hospitalization in the hospitals involved is not covered by a contract between the hospital plan corporation and such hospitals.

(5) Retroactivity.—Upon the settlement of any dispute between a hospital plan corporation and any hospital pursuant to paragraphs (2) and (4), the terms and conditions of any new contract shall be retroactive to the date of expiration of the contract previously in effect between the parties.

Section 2.[99]

The procedures established by this act shall apply to:

(1) any termination of contracts between hospital plan corporations and hospitals hereafter occurring; and

(2) any contracts between hospital plan corporations and hospitals under which subscribers received prepaid benefits on or after June 30, 1974 if such hospital plan corporations and hospitals were governed by contracts subject to 40 Pa. C. S. Chap. 61 (relating to hospital plan corporations) or corresponding provisions of law on June 30, 1964 and substantially continuously thereafter to and including June 30, 1974. Such contracts, if terminated, shall be reinstated as of their original termination and may be terminated hereafter only pursuant to the provisions of this act.

Section 3.[1]

This act shall take effect immediately and shall be retroactive to the extent provided in section 2 of this act.

Approved the 2nd day of Aug. A. D. 1975.

99. 40 Pa. C. S. A. § 6124 note.

1. 40 Pa. C. S. A. § 6124 note.

APPENDIX B.

OPINION OF THE DISTRICT COURT.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF
PENNSYLVANIA.

Civil Action No. 75-2306.

PAUL I. GUEST,
President of Methodist Hospital;
CHARLES H. FRENZEL, Executive Vice President
of Mercy Catholic Medical Center;
PHILIP J. SAWLINSKY, Manager of Patient Accounts
of ST. JOSEPH'S HOSPITAL; and
METHODIST HOSPITAL, on Behalf of Themselves
. and All Others Similarly Situated

v.

EMMETT F. FITZPATRICK, JR.,
District Attorney of Philadelphia,
ROBERT P. KANE, Attorney General of the
Commonwealth of Pennsylvania, Individually and
in Their Official Capacities, and
BLUE CROSS OF GREATER PHILADELPHIA.

Before VAN DUSEN, *Circuit Judge*, and
LUONGO and WEINER, *District Judges*.

WEINER, *J.* February 27, 1976

This is an action brought by several hospitals, members of the Delaware Valley Hospital Council (hereinafter

DVHC) for declaratory judgment and injunctive relief, challenging the provisions of a Pennsylvania law, Act No. 94, 40 Pa. C. S. § 6124(c), effective August 2, 1975. Act No. 94 creates statutory requirements for the termination of contracts between hospitals and certain hospital plan corporations. Jurisdiction of this Court was invoked pursuant to 28 U. S. C. § 1331, and 28 U. S. C. § 1343(3), and a three-judge court was convened as required by 18 U. S. C. § 2284. The court has for its consideration cross motions for summary judgment filed by plaintiffs and defendants respectively.[1]

Since the facts are not in dispute, there remain solely questions of law. From our examination of the record, the following facts emerge: On August 15, 1974, the contract between defendant Blue Cross of Greater Philadelphia and plaintiff hospitals expired. Run-out provisions of the contracts between Blue Cross and individual subscribers then began to take effect, and coverage expired on the anniversary dates of the subscription contracts. The last subscriber contracts were to run out on August 15, 1975. During the one-year following expiration of the above contract, negotiations toward a new contract proved to be unsuccessful. The effect of the run-out provisions would have been to limit most subscribers' coverage to that afforded in non-Blue Cross member hospitals. Traditionally, an individual enters into a subscription contract with Blue Cross. In the majority of cases, the insurance plan will obtain hospital services in member

1. Due to a stipulation filed 9/25/75, stating that defendants Fitzpatrick and Kane agree not to seek criminal sanctions while Act No. 94 remains subject to constitutional challenge but apparently reserving their right to proceed against plaintiffs after final determination of this suit, there is a case or controversy continuing insofar as plaintiffs seek final injunctive relief. The absence of any demand for damages requires that the Pennsylvania defendants' claims for immunity under the Eleventh Amendment be rejected. See *Edelman v. Jordan*, 415 U. S. 651, 664-65 (1974).

hospitals. The coverage afforded is then either complete coverage, i.e., the full hospital service is provided, or the subscriber pays a relatively small portion of the hospital fee. In either event, Blue Cross makes direct payment to the hospital. If the subscriber is admitted to a hospital which is not a member hospital, the subscriber will be fully responsible for his hospital costs and Blue Cross will partially reimburse the subscriber directly. Typically, only a small portion of the total hospital bill is repaid to the subscriber.

In situations in which total coverage is provided subscribers, it is clearly necessary that there be a contractual relationship between Blue Cross and the hospitals. Hence, the term "member hospitals". The contract between Blue Cross and its member hospitals operates on a cost reimbursement formula. Under such a formula, the retail price of hospital services is not paid by Blue Cross. Rather, Blue Cross reimburses hospitals for the cost to the hospitals of providing care to the subscriber, computed in a way that allows, inter alia, for consideration of depreciation and economic inflation factors.

It was the cost reimbursement formula that led to the breakdown of negotiations for new contracts between Blue Cross and the plaintiff hospitals who are represented by the DVHC.

During the one-year period of negotiations, increasing numbers of subscribers lost member hospital benefits in the plaintiff hospitals. On August 2, 1975, the Pennsylvania legislature passed, and the Governor signed, Act No. 94, 40 Pa. C. S. § 6124(c).

Chapter 61 of Title 40 establishes statutory control over hospital plan corporations. Defendant Blue Cross of Greater Philadelphia is a hospital plan corporation within the meaning of the statute. The Hospital Plan Corporation

Act generally provides for regulation of hospital plan corporations and specifically requires, *inter alia*, that all hospital plan corporations obtain certificates of authority from the Pennsylvania Department of Insurance (§ 6102(a)); that hospital plan corporations enter into contracts only with hospitals approved by the Department of Public Welfare (§ 6121).

Section 6124 of the Hospital Plan Corporation Act, which section Act No. 94 amends, provides:

> (a) The rates charged to subscribers by hospital plan corporations, all rates of payments to hospitals made by such corporations pursuant to the contracts provided for in this chapter, all acquisition costs in connection with the solicitation of subscribers to such hospital plans, the reserves to be maintained by such corporations, the certificates issued by such corporations representing their agreements with subscribers, and any and all contracts entered into by any such corporation with any hospital, shall, at all times, be subject to the prior approval of the department.
>
> (b) Every application for such approval shall be made to the department in writing . . .

Act No. 94 which amends the above section, provides:

> Section 1. Section 6124 of Title 40, . . . is amended by adding a subsection to read:
>
> § 6124. Rates and contracts
>
> (c) Maintenance of contractual relationship.
>
> (1) *Declaration of necessity*—It is hereby found that many subscribers to nonprofit hospital plans make payments over long periods of time prior to becoming entitled to benefits under such a plan and that

> it is important in the public interest that the reasonable expectations of such subscribers as to coverage should be fulfilled if possible. It is hereby declared to be essential for the maintenance of the health of the residents of this Commonwealth that subscribers to nonprofit hospital plans be assured receipt of the hospitalization and related health benefits pre-paid by them through payments of the rates approved under this chapter and charged by a hospital plan corporation and that to accomplish this essential purpose termination of contracts between hospital plan corporations and hospital entered into pursuant to section 6121 (relating to eligible hospitals) and this section be subject to prior approval by the department as provided in this subsection.
>
> (2) *Notification period*—No contract between a hospital plan corporation and any hospital providing for the rendering of hospitalization to subscribers to the hospital plan shall be terminated unless the party seeking such termination gives 90 days advance written notice to the other party to the contract and to the department of the proposed termination.
>
> (3) *Hearing period*—Whenever a termination subject to paragraph (2) involves contracts with hospitals having more than 5% of the beds in the area served by a hospital plan corporation, the department shall hold public hearings on at least 15 days no-

tice for the purpose of investigating the reasons for the termination. Pending completion of said investigation by the department, termination of the hospital contracts shall be suspended for a period not to exceed six months from the expiration of the period provided for in paragraph (2). All terms and conditions of the contract between the hospital plan corporation and the hospital or hospitals shall continue in full force and effect during said investigation by the department. Based on the record made during the hearings, the department shall make specific findings as to the facts of the dispute and shall either approve termination of the contracts or recommend such terms for continuation of the contract as are in the public interest, based upon the facts, the right of a hospital to be paid its costs for hospitalization services to subscribers and the need of subscribers for efficient, reliable hospitalization at a reasonable cost.

(4) *Negotiation period*—If the department recommends terms for continuation of the contract, the hospital plan corporation and the hospitals involved shall renew their negotiations in order to determine whether a new agreement can be reached substantially on the basis of the terms for continuation recommended by the department and pending such negotiations, the termination of hospital contracts shall be suspended for a further period not to exceed 90 days from the date of the decision of the department.

If the hospital plan corporation and the hospitals are unable to consummate a new contract within said further period of 90 days, they shall so advise the department. The department shall in that event approve termination of the contracts effective at the end of a further period of 30 days and shall prescribe the form and extent of notice which the hospital plan corporation shall use in advising its subscribers that hospitalization in the hospitals involved is not covered by a contract between the hospital plan corporation and such hospitals.

(5) *Retroactivity*—Upon the settlement of any dispute between a hospital plan corporation and any hospital pursuant to paragraphs (2) and (4), the terms and conditions of any new contract shall be retroactive to the date of expiration of the contract previously in effect between the parties.

Section 2. The procedures established by this act shall apply to:

(1) any termination of contracts between hospital plan corporations and hospitals hereafter occuring; and

(2) any contracts between hospital plan corporations and hospitals under which subscribers received prepaid benefits on or after June 30, 1974 . . . . Such contracts, if terminated, shall be reinstated as of their original termination and may be terminated hereafter only pursuant to the provisions of this act.

Section 3. This act shall take effect immediately and shall be retroactive to the extent provided in section 2 of this act.

The effect of Act No. 94 on the Plaintiff hospitals is to reinstate the most recent contract between the DVHC represented hospitals and Blue Cross as of its original termination date, namely, August 15, 1974. If the hospitals wish to terminate the contract, they must follow the provisions of the Act. If a new contract is negotiated by the parties and approved by the Insurance Department, that new contract will date back to the termination of the previous agreement. However, since August, 1974,[2] the hospitals have been requiring Blue Cross subscribers to pay for hospital care as is the practice in non-member hospitals. The hospitals are now faced with the prospect of repaying those subscribers and receiving only cost reimbursement from Blue Cross under the 1971 Contract.[3]

The hospitals' contention is that Act No. 94 violates their Constitutional rights. They claim that the retroactivity of the Act, which reinstates the contract which expired on August 15, 1974, is in violation of the Contract Clause and of the Due Process Clause of the United States Constitution. Specifically, the hospitals claim that the Act effects an unconstitutional taking of property without just compensation and also violates the Equal Protection Clause of the United States Constitution.

The Contract Clause, Article I, § 10 of the United States Constitution provides that no State shall pass any law impairing the obligation of contracts. The plaintiff-hospitals' contention is that Act No. 94 constitutes a

2. This date is, of course, variable, because of the run-out provisions of subscribers' contracts.

3. The contract which expired on August 15, 1974 was entered into in 1971 and amended in 1972.

"wholesale evisceration of plaintiffs' contractual rights of termination". We believe that this is not the case at all here.

The Contract Clause came into widespread use in litigation during the depression years when many States passed statutes designed to aid financially distressed citizens, unable to satisfy previously entered-into contractual obligations. The case of *Home Building and Loan Assn. v. Blaisdell, et al.*, 290 U. S. 398 (1933) sets forth the standards to be applied to state legislative enactments to determine whether or not such legislation offends the Contract Clause. At issue in that case was the 1933 Minnesota Mortgage Moratorium Law which provided relief from mortgage foreclosure during a declared emergency. In its opinion up-holding the statute, the Supreme Court stated:

> "Not only are existing laws read into contracts in order to fix obligations as between the parties, but the reservation of essential attributes of sovereign power is also read into contracts as a postulate of the legal order. The policy of protecting contracts against impairment presupposes the maintenance of a government by virtue of which contractual relations are worth while,—a government which retains adequate authority to secure the peace and good order of society. The principle of harmonizing the constitutional prohibition with the necessary residuum of state power has had progressive recognition in the decisions of this Court." *Id.* at 435.

The plaintiffs' argument is, in essence, that the statutory extension period violates their contract right of termination on ninety days notice as to any contract entered into between the hospitals and Blue Cross. We

are of the opinion that the public interest of preserving the health of the citizens of Pennsylvania adequately justifies such a measure.[4] More than 50% of the citizens have health care insurance coverage through Blue Cross. Most, if not all, of these policyholders, it can be assumed, maintain Blue Cross insurance because of the virtually complete coverage offered by Blue Cross at member hospitals. The current contract dispute, with the resulting run-out of subscribers' member hospital coverage eliminated many hospitals in the Philadelphia area from member hospital status.[5] Therefore, numerous Pennsylvanians who had prepaid and expected member hospital subscriber coverage, found their coverage reduced to non-member coverage at many hospitals.

The maintenance of the health and general well-being of its citizens has been found to be a legitimate state concern and has formed the basis of numerous judicial decisions up-holding state legislative action.[6] Likewise, in this case, it is precisely because the public interest is so substantial in the area of health care that legislation gov-

4. The case of *Travelers Insurance Co. v. Blue Cross of Western Pa.*, 361 F. Supp. 774 (W. D. Pa. 1972), *aff'd* 481 F. 2d 80 (3d Cir. 1973), *cert. denied* 414 U. S. 1093 (1974), sustained the general provisions of Blue-Cross hospital contracts against charges of violation of the antitrust laws. In that case, it was stated that a study of the health care problem in Pennsylvania by the Pennsylvania Economy League showed that ". . . it was common for people to forego needed hospitalization because they lacked money to pay the bills." 361 F. Supp. 774, 776.

5. Thirty-seven (37) hospitals in the Philadelphia area are represented by the DVHC. Non-member hospital coverage for subscribers is approximately 25% of hospital costs.

6. See e.g., *Nebbia v. New York*, 291 U. S. 502 (1934) in which regulation of the sale price of milk authorized by a New York statute was upheld as being reasonably related to the goal of protecting the welfare of the citizens of New York. In its opinion, the Supreme Court stated that support for this statute could be found from the fact that the milk industry in general was heavily regulated in New York.

erning hospitals and hospital plan corporations has been enacted in Pennsylvania.[7] Act No. 94 is a logical and reasonable extension of that legislation.

We have carefully considered the cases cited by our brother Judge Luongo and find them to be distinguishable.[8] The Supreme Court, in *El Paso v. Simmons*, 379 U. S. 497 (1965), stated that it has long been recognized that state legislatures have the power to safeguard the vital interests of their citizenry.[9] The distinction to be drawn is not solely between legislation of substantive and remedial contract provisions but, rather, between legislation which affects contractual rights and obligations in purely commercial enterprises and legislation which concerns the health and welfare of the people. The need of Pennsylvanians for medical insurance which enables them to receive hospital care during health crises is a need which will, unfortunately, touch most citizens during their lifetimes. The public interest underlying Act No. 94 clearly justifies any incursions it makes into the contract rights of the parties here.

In *Fornaris v. Ridge Tool Co., et al., supra*, the Court of Appeals found unconstitutional a Puerto Rican statute which provided that contracts between manufacturers and dealers, regardless of their terms, were, with certain exceptions, to be renewable at the option of the dealer and which imposed substantial damages on manufacturers who refused to accede. The court found that the new contractual obligations were excessive in light of the reasonable expectations of the parties. Here in contrast the con-

7. 40 Pa. C. S. § 6101, *et seq.*

8. *Fornaris v. Ridge Tool Co., et al.*, 423 F. 2d 563 (1st Cir. 1970), rev'd. on other grounds, 400 U. S. 41 (1971); *Superior Motors, Inc. v. Winnebago Industries, Inc.*, 359 F. Supp. 773 (D. S. C. 1973).

9. *Id.* at 508.

tracts are still terminable at the end of approximately one year by the hospitals without penalty and their expectations, as a regulated industry are different from those of the commercial manufacturers in *Fornaris*.

Plaintiffs further contend that Act No. 94 violates the Due Process and Equal Protection Clause of the United States Constitution. Their argument is based in part on the theory that the cost reimbursement formula contained in the Blue Cross-hospital contracts does not include such items as indigent care, charity allowances, uncollectible amounts or research costs and thereby renders the contracts non-compensatory and constitutes a taking of property without just compensation. The validity of such clauses in Blue Cross-hospital contracts has already been upheld.

The case of *Travelers Insurance Company v. Blue Cross of Western Pennsylvania, supra*, upheld Blue Cross-hospital contracts against claims by a commercial insurer that the contractual arrangements between Blue Cross of Western Pennsylvania and hospitals violated the antitrust laws. Specifically, Travelers contended that Blue Cross was a dominant competitor monopolizing the hospital insurance industry by pressuring hospitals to enter into contractual arrangement which favored Blue Cross over other commercial insurers. The favored treatment claim arose from the failure of Blue Cross-hospital contracts to include in the reimbursement formula such items as indigent care, and the resulting lower cost to Blue Cross for hospital services. The court, in its opinion, upholding the above-mentioned contract clauses stated that the Insurance Department had mandated a ceiling on cost reimbursement, and the exclusion from the reimbursement formula of the cost of free care and capital expansion. We see nothing in the challenge to cost reimbursement formula in

the instant case to distinguish it from the reimbursement terms found to be valid in *Travelers*.

We note that the court stated with reference to the Pennsylvania Hospital Plan Corporation Act (40 Pa. C. S. A. § 6106 ff.) in *Travelers, supra*, at page 86 of 481 F. 2d:

> "In view of our holding that, independent of the McCarran-Ferguson Act, the antitrust laws were not violated, the state of Pennsylvania has not denied Travelers equal treatment in violation of the Fourteenth Amendment. Furthermore, even if McCarran-Ferguson Act protection were necessary to Blue Cross, the facts do not support the proposition that Pennsylvania's regulation of the contract between Blue Cross and the hospitals was without rational purpose, *see, e.g., James v. Strange*, 407 U. S. 128, 92 S. Ct. 2027, 32 L. Ed. 2d 600 (1972)."

In addition, plaintiffs claim that the loss sustained by virtue of the fact that the above-mentioned costs are not reimbursed is further exacerbated by the ceiling limitation on reinstatement of allowable costs. The question of the economic viability of hospitals as a result of the reinstatement of the previously-terminated contract is a matter for the legislative process as distinguished from judicial inquiry. Under the Hospital Plan Corporation Act, the Insurance Department is authorized to approve or disapprove proposed contracts pursuant to specific guidelines.[10] Act No. 94 itself provides that during the suspension period, the Insurance Department shall either approve termination of the contract or shall ". . . recommend such terms of continuation of the contract as are in the public interest, based upon the facts, the right of a hospital to be paid its

10. 40 Pa. C. S. § 6124(a) & (b).

costs for hospitalization services to subscribers and the need of subscribers for efficient, reliable hospitalization at a reasonable cost." [11] Plaintiff hospitals have filed a Notice of Intent to Terminate with the Insurance Department and have so notified Blue Cross. Therefore, the question of the non-compensatory nature of the reinstated contract is one to be determined by the Insurance Department.

Plaintiffs argue that Act No. 94 is subject to challenge on constitutional grounds predicated upon the theory that the retroactive application of the statute constitutes a taking of property without due process and plaintiffs further reiterate their previous argument of "impairment of contract." Here, the plaintiffs focus upon the provisions of Act No. 94 which, in substance and effect, provide: (a) that contracts between the hospitals and Blue Cross which terminated in August 1974 be reinstated and (b) that, as a result, subscribers who paid in full for hospitalization during the eleven and a half month period preceding the passage of Act No. 94 be reimbursed for all charges which would have been reimbursed to subscribers under the 1971 Agreement. We find that the statutory reinstatement of terminated contracts and their cost reimbursement formulae and the resulting mandatory reimbursement of subscribers are not unconstitutional.

The unanticipated inability of Blue Cross and the hospitals to negotiate a new contract in 1974 created extreme financial hardship for Blue Cross subscribers hospitalized after the contractual run-out provisions had taken effect. Act No. 94 is designed to avoid the recurrence of such a situation in the future. As part of the remedial nature of the statute, hospitals with long-standing contracts with Blue Cross were required to reinstate the most recent contract provisions. This remedial measure is

11. 40 Pa. C. S. § 6124(c)(3).

strikingly similar to remedial measures in other regulatory statutes regarding disputed rates charged by regulated corporations.[12] In *Fleming v. Rhodes*, 331 U. S. 100 (1947), the Supreme Court held that rights previously acquired can be legislatively reinstated retroactively. Here, subscribers contracted with and prepaid Blue Cross for health care coverage. As part of that contract, hospitalization at member hospitals was to be provided at little or no cost to the subscriber. The crisis created by the failure of contract negotiations between Blue Cross and the hospitals placed a heavy burden on subscribers. Act No. 94, in its declaration of necessity, states that subscribers are entitled to receive benefits for which they have paid in advance. The subscribers hospitalized between August, 1974 and August, 1975 did not receive those health care benefits. Act No. 94 simply places them in the same position as subscribers hospitalized prior to August, 1974 and subsequent to August, 1975.

The retroactive effect of statutes has been approved where they have filed gaps in the regulatory scheme. See *Fleming v. Rhoades, supra;* C. Hochman, "The Supreme Court and the Constitutionality of Retroactive Legislation," 73 Harv. L. Rev. 692 (1960). The Supreme Court has recognized in the labor field that contractual arrangement may be "continued for a time while further efforts [are] made to settle the dispute." See *Steelworkers v. United States*, 361 U. S. 39, 41 (1959). Further, the Supreme Court has held that the taking of property under a program clearly in the public interest is not a denial of due process of law, using this language in *Day-Brite Lighting, Inc. v. Missouri*, 342 U. S. 421, 424-25 (1952):

12. For example, the Interstate Commerce Act, 49 U. S. C. § 15(7) authorizes the ICC to require that carriers refund, with interest, increased rates found to be not justified. And, in *Nebbia v. New York, supra*, a New York statute authorizing the Milk Control Board to fix milk prices in the state was upheld.

"Of course many forms of regulation reduce the net return of the enterprise; yet that gives rise to no constitutional infirmity. [Citing cases.] Most regulations of business necessarily impose financial burdens on the enterprise for which no compensation is paid. Those are part of the costs of our civilization . . . . The public welfare is a broad and inclusive concept. The moral, social, economic, and physical well-being of the community is one part of it; the political well-being another. The police power which is adequate to fix the financial burden for one is adequate for the other. The judgment of the legislature that time out for voting should cost the employee nothing may be a debatable one. It is indeed conceded by the opposition to be such. But if our recent cases mean anything, they leave debatable issues as respects business, economic, and social affairs to legislative decision. We could strike down this law only if we returned to the philosophy of the *Lochner, Coppage* and *Adkins* cases."

The affidavits of plaintiff are far too generalized to justify the grant of summary judgment in their favor. Although the dissenting opinion alleges that plaintiff-hospitals "are compelled to operate at charges they contend are below the level of operating expenses . . . and that are . . . confiscatory," the affidavit of Mr. Armstrong in support of plaintiffs' Motion for Summary Judgment, at paragraph 6, objects to the failure of defendant to pay "the expenses incurred by the hospital in providing care to indigents, in writing off uncollectible accounts other than those of Blue Cross subscribers, in providing charity allowances, and in undertaking certain educational and research activities." Cf. paragraph 61 of supplemental

affidavit of Bruce Taylor dated October 14, 1975. Defendant does not require plaintiffs to undertake such expenses, so that plaintiffs have failed to show that the expenses incurred by plaintiffs under Act No. 94 are the cause of the anticipated confiscatory effect of continuing operations under the Delaware Valley Agreement. The affidavits filed by plaintiffs fail to show with any specificity that the cause of their anticipated losses is Act No. 94, as opposed to their desire to provide service for their communities in accordance with the standards of the American Hospital Association (see, for example, page 18 of Plaintiffs' Memorandum, referring to the cost of "educational and research programs, credit losses, and the care of [indigent] patients . . .", and paragraph 15 of Mr. Armstrong's affidavit referring to "health care services required to maintain its accreditation" without making specific such generalities).

Plaintiffs' equal protection arguments are founded on the claim that Act No. 94 imposes burdens only on member hospitals, leaving non-member hospitals unregulated. It is true that neither Act No. 94 nor the Hospital Plan Corporation Act regulates non-member hospitals. The obvious reason seems to be that the Hospital Plan Corporation Act regulates hospital plan corporations and those hospitals with whom they contract. As a result of the agreements between hospitals and hospital plan corporations, members of the general public enter into contractual agreements with the hospital plan corporation for the provision of health care benefits at member hospitals. Hospital plan corporations are required to receive certification from the Pennsylvania Insurance Department.[13] Hospitals which enter into agreements with

13. 40 Pa. C. S. § 6102.

hospital plan corporations likewise must be approved by the Department of Public Welfare.[14]

And, finally, contracts between hospital plan corporations and hospitals must receive Insurance Department approval.[15] Whereas member hospitals provide virtually total coverage for hospitalization and health care, and are reimbursed under the approved contract formula by Blue Cross, non-member hospitals receive full payment from subscribers, who are then only partially reimbursed by Blue Cross.

The determination of the legislature to regulate only member hospitals by Act No. 94 is not violative of equal protection. Under the equal protection clause, the test applied to any classification scheme set up by a state legislative body is whether the scheme has a rational basis.[16] The burden is on plaintiffs to show that the classification scheme has no rational basis. Since non-member hospitals, by definition, have no contractual arrangement with Blue Cross, they were not included in a statute which regulates hospital plan corporations and, as incident to that regulation, hospitals with whom the corporations contract. In *Nebbia v. New York, supra,* appellant claimed that a New York statute authorizing establishment of minimum resale prices of milk for stores denied him equal protection because it enabled door-to-door distributors to provide additional services at an almost identical price. Specifically, the Milk Control Board had fixed the minimum price to be charged by a store and by a distributor for a quart of milk at nine and ten cents respectively. In its opinion, the Supreme Court stated: "But if it were shown that the appellant is compelled to buy [from a wholesale

14. 40 Pa. C. S. § 6121.

15. 40 Pa. C. S. § 6124.

16. See e.g., *German Alliance Insurance Company v. Hale,* 219 U. S. 307 (1911).

distributor and not directly from a farmer] the difference in the retail price he is required to charge his customers, from that prescribed for sales by distributors, is not on its face arbitrary or unreasonable, for there are obvious distinctions between the two sorts of merchants which may well justify a difference of treatment, if the legislature possesses the power to control the prices to be charged for fluid milk." Id. at 521. Because of the substantial difference in subscriber benefits provided by member and non-member hospitals here, it cannot be gain-said that the statutory distinction has no reasonable basis.

The foregoing shall constitute the findings and conclusions of the court on the plaintiffs' motion for injunctive relief, and such motion will be denied. The joint motions of defendants Blue Cross, Fitzpatrick, Kane and the Insurance Department for summary judgment will be granted, and the motions of plaintiffs for summary judgment will be denied.

ORDER OF THE DISTRICT COURT.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF
PENNSYLVANIA.

Civil Action No. 75-2306

PAUL I. GUEST,
President of Methodist Hospital;
CHARLES H. FRENZEL, Executive Vice President
of Mercy Catholic Medical Center;
PHILIP J. SAWLI. SKY, Manager of Patient Accounts
of ST. JOSEPH'S HOSPITAL; and
METHODIST HOSPITAL, on Behalf of Themselves
and All Others Similarly Situated

v.

EMMETT F. FITZPATRICK, JR.,
District Attorney of Philadelphia,
ROBERT P. KANE, Attorney General of the
Commonwealth of Pennsylvania, Individually and
in Their Official Capacities, and
BLUE CROSS OF GREATER PHILADELPHIA

ORDER

The motion of Plaintiffs for summary judgment is DENIED.

The motions of defendants for summary judgment are hereby GRANTED.

IT IS SO ORDERED.

/s/ FRANCIS L. VAN DUSEN
Francis L. Van Dusen
/s/ CHARLES R. WEINER
Charles R. Weiner

APPENDIX C.

DISSENTING OPINION.

LUONGO, J., dissenting

I agree that this is a matter which affects the health and welfare of the citizens of Pennsylvania. I agree also that the aim of this legislation—to protect the ultimate consumers' need for continued hospital plan protection—is commendable and is certainly within the police power of the state. In my view, however, the legislation misses the constitutional mark when it requires the hospitals to remain parties to the contract beyond the bargained for notice period without making some provision to compensate them for the losses they may incur during the period of enforced adherence to the terms of the last negotiated contract. Act 94 works an impermissible impairment of contractual obligations in violation of the Contract Clause of the Constitution, and amounts to a taking of property without just compensation in violation of the Fourteenth Amendment to the Constitution.

The constitutionally offensive aspect of Act 94 is its retrospective effect. The Act, passed August 2, 1975, applies to any contract then in effect between a member hospital and a hospital plan corporation, or any contract "under which subscribers received prepaid benefits on or after June 30, 1974. . . . Such contracts, if terminated, shall be reinstated as of their original termination and may be terminated hereafter only pursuant to the provisions of this act." 40 P. S. § 6124(c)2(2). Since the contracts, entered into in 1971, and amended in 1972, contain run-out provisions requiring payment for hospital services rendered after the termination date to subscribers who had been admitted prior to termination, the Act covers contracts which had, in fact, terminated prior to June 30, 1974.

Undoubtedly a state may constitutionally enact legislation imposing conditions on the termination of contracts entered into subsequent to the passage of the legislation, but the state oversteps the bounds when it imposes such conditions upon contracts entered into prior to the adoption of the legislation without providing some measure of protection against loss to the party affected.

Act 94 requires hospitals and the various hospital plan corporations, including Blue Cross, to continue to adhere to the terms of their last negotiated contract for approximately a year beyond the termination date provided in the contract. The effect of the Act is to force contracting hospitals to continue to provide care to subscriber patients at increasing current costs, while reimbursement from the hospital plan corporations is based on previously negotiated cost calculations and formulae which the hospitals claim is insufficient to reimburse them for their expenses.

The cost formulae adopted in the earlier negotiated contracts do not allow to the hospitals, as reimbursable expenses, most community service activities, including care provided to indigents, writing off uncollectible accounts of patients not insured under a contracting hospital plan corporation, providing charity allowances, and undertaking certain education and research activities. Private paying patients or patients with private insurers have, accordingly, always paid a disproportionate share of such expenses. In earlier years there apparently existed sufficient numbers of such patients, and the hospital plan corporation arrangement had sufficient advantages, to make it financially feasible for the hospitals to enter into such agreements. Under the present arrangement, more individuals will likely become subscriber patients because of the relatively lower premiums the hospital plan corporations can charge, since under Act 94 the hospital plan corporations will pay

to the hospitals less than private insurers or self-paying patients will be required to pay. Thus an increasingly higher percentage of the hospitals' patients will not be paying their share of the cost of the hospitals' community service activities. Moreover, subscriber patients will be paying for hospital services, through the hospital plan corporation, rates which do not fully reflect the escalating costs caused by the inflationary spiral. The contracting hospitals have thus been forced by the state into furnishing services at charges lower than their actual expenses of furnishing such services. True, the Act does provide that *if* a new contract is negotiated during the extension period, "the terms and conditions of any new contract shall be retroactive to the date of expiration of the contract previously in effect between the parties." *If* a new contract is negotiated between the parties, it would presumably make allowance, satisfactory to the hospitals, for the hospitals' costs of operation. There is no assurance, however, that a new contract which will fairly compensate the hospitals for their costs, *will* be negotiated and entered into, and no provision is made to compensate the hospitals for their losses incurred in the interim period if no new contract is negotiated.

Act 94 clearly has the effect of modifying the contracts that existed between member hospitals and Blue Cross. The majority does not dispute the modifying effect, but finds that the public interest of preserving the health of Pennsylvania citizens justifies the measure. It is true that where the public welfare requires, the state may use its police power in a manner which, to some degree, impairs the obligations of existing contracts, but the states' power to do so is limited. Here the effective excision of the termination clause from the contract is too substantial an impairment, I believe, to be constitutionally permissible. Both parties to the contract bargained for benefits and

burdens they were willing to accept and assume for a certain period of time, subject to their right to terminate at the end of the stated period upon giving 90 days' notice. The excision of that termination provision has the effect of forcing the hospitals to provide, beyond the agreed period, services at charges the hospitals now claim to be below operating cost level, and which are therefore confiscatory.[1]

No matter how great the public need, the state may not, without violating the Fourteenth Amendment, take property without just compensation. The due process and impairment of contract claims are not readily separable, and an impairment claim will usually give rise to a due process claim. *See Fornaris v. Ridge Tool Co.*, 423 F. 2d 563, 566-67 (1st Cir. 1970), *rev'd on other grounds*, 400 U. S. 41 (1971). In the present suit, there is concededly an impairment. I believe the impairment to be so substantial as to violate the Contract Clause, and in any case the impairment works a taking of property without due process of law. The case authority is not to the contrary.

In *Home Building & Loan Association v. Blaisdell*, 290 U. S. 398 (1934), the Supreme Court upheld a state statute which retroactively extended the period during which a defaulting mortgagor could redeem property which had been foreclosed. Although the contract rights of the parties were altered, the Court found the statute constitutionally sound because the substantive rights of the parties were not impaired:

> "The statute does not impair the integrity of the mortgage indebtedness. The obligation for interest remains. The statute does not affect the validity of the sale or the right of the mortgagee-purchaser to title in fee, or his right to obtain a deficiency judgment, if the

1. The affidavits of Messrs. Armstrong, Guest and Williamson may not be sufficient to establish that the imposed rates are confiscatory, but at the very least they raise a material issue of fact for trial.

> mortgagor fails to redeem within the prescribed period. Aside from the extension of time, the other conditions of redemption are unaltered. *While the mortgagor remains in possession he must pay the rental value as that value has been determined, upon notice and hearing, by the court.* The rental value so paid is devoted to the carrying of the property by the application of the required payments to taxes, insurance, and interest on the mortgage indebtedness. While the mortgagee-purchaser is debarred from actual possession, he has, so far as rental value is concerned, the equivalent of possession during the extended period." (Emphasis supplied)

290 U. S. at 425.

Where legislation has been applied retroactively and has altered the substantive contractual rights of the parties, the Supreme Court has invalidated it. In *Louisville Joint Stock Land Bank v. Radford,* 295 U. S. 555 (1935), the Court struck down the Frazier-Lemke Act, a federal law which permitted mortgagors to redeem property at its appraised value, regardless of the amount of the outstanding debt. The Court held that the forced surrender of possession and title to property, so long as any part of the debt secured thereby remained unpaid, effected a taking of property without just compensation and could not be justified, however great the public need. The Court distinguished *Blaisdell, supra,* on the ground that in Blaisdell no substantive right had been abridged. *Id.* at 581. *W. B. Worthen Co. v. Kavanaugh,* 295 U. S. 56 (1935), reaches the same conclusion. In that case the Supreme Court struck down a state statute extending the period of redemption on grounds it violated the Contract Clause. Again the Court found that the substantive rights of the parties had been altered by the legislation in that the

mortgagor was permitted to retain possession of the property without the payment of interest, taxes or rent. In the instant suit, the state has substantially extended the period of the contract and has thereby imposed terms on the hospitals which they claim make it impossible for them to meet their expenses without dipping into reserves. This clearly places the case in line with *Radford* and *Worthen,* and not *Blaisdell.*

Day-Brite Lighting, Inc. v. Missouri, 342 U. S. 421 (1952), is as readily distinguishable as *Blaisdell.* That case involved a state statute which permitted employees to absent themselves from work for several hours, without loss of pay, to vote. In upholding the constitutionality of such legislation, the Supreme Court spoke only of the permissibility of state regulations which impose financial burdens upon, and reduce "the net return" from business enterprises. That is a far cry from the plight of these non profit hospitals which contend they are being required to operate at inadequate and confiscatory levels of reimbursement.

Even if this were regarded as a "rate" case, which I think it clearly is not, "[a]s of right safeguarded by the due process clause of the Fifth Amendment, [the regulated entity] is entitled to rates, not *per se* excessive and extortionate, sufficient to yield a reasonable rate of return upon the value of property used, at the time it is being used, to render the services." *Denver Union Stock Yard v. United States,* 304 U. S. 470, 475 (1938). A *fully* regulated utility cannot be compelled to absorb its own costs and not pass them on to the consumer. *Public Service Commission v. Federal Power Commission,* 467 F. 2d 361, 370 (D. C. Cir. 1972). Even temporary rates which are confiscatory are not permissible. *Prendergast v. New York Telephone Co.,* 262 U. S. 43, 49 (1923). *Cf. Beaver Valley Water Co. v. Driscoll,* 28 F. Supp. 722 (W. D. Pa. 1939).

In the case perhaps most nearly on point, the Court of Appeals for the First Circuit held unconstitutional, as applied to contracts entered into before its passage, a Puerto Rican law which prohibited a manufacturer from terminating a dealership contract unless justified by a substantial failure of performance by the dealer. *Fornaris v. Ridge Tool Co.*, 423 F. 2d 563 (1st Cir. 1970), *rev'd on other grounds*, 400 U. S. 41 (1971). Chief Judge Aldrich based the decision on the Fifth[2] Amendment Due Process Clause, stating that it was unnecessary to deal with the impairment of contracts issue "because the due process clause of the federal constitution provides essentially the same restraint so far as retrospectivity is concerned." He noted that "[i]n determining whether retroactive alteration of contractual provisions are sufficiently minor to be permissible a distinction is sometimes drawn between alteration of substantive rights and alteration of procedures or remedies," and that "[n]o amount of research by parties or amici has discovered a case suggesting that . . ." a statute converting a contractual relationship from one terminable without cause to terminable only for just cause was not one that worked "a change of great magnitude." *Id.* at 567-68 (footnotes omitted). A similar state statute modifying manufacturers' termination rights under franchise agreements was held unconstitutional, this time on the basis of the Contract Clause, in *Superior Motors, Inc. v. Winnebago Industries, Inc.*, 359 F. Supp. 773 (D. S. C. 1973). In my view, the statute in the present case is more egregious than those in *Fornaris* and *Superior Motors* since it prohibits termination altogether during the period of extension.

2. The Fifth, rather than the Fourteenth, Amendment because Puerto Rico is not a state. See generally, discussion in footnotes 7 and 8, *id.* at 566-67.

The Contract Clause is not an absolute barrier to state legislative enactments which have the effect of modifying existing contracts, and there is no question but that a state may regulate enterprises affecting the public interest, but the Constitution sets limits to the manner and degree in which the state may exercise its police power. In the present instance, the failure of the contracting parties to come to an agreement has resulted in an unfortunately hasty reaction by the Pennsylvania legislature which, I believe, exceeds those limits by failing to make provision to protect the hospitals against loss during the period of extension.

Accordingly, I respectfully dissent.

ALFRED L. LUONGO
Alfred L. Luongo

APPENDIX D.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 75-2306

PAUL I. GUEST, et al.

v.

F. EMMETT FITZPATRICK, et al.

NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES.

Notice is hereby given that Paul I. Guest, et al., the above-named plaintiffs, hereby appeal to the Supreme Court of the United States from the final order denying plaintiffs' motion for summary judgment and granting defendants' motion for summary judgment, entered in this action on February 27, 1976.

This appeal is taken pursuant to 28 U. S. C. § 1253.

JAMES D. CRAWFORD
Attorney for Plaintiffs

SCHNADER, HARRISON, SEGAL & LEWIS
1719 Packard Building
Philadelphia, Pennsylvania 19102
Of Counsel.

Dated: March 22, 1976

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 75-2306

PAUL I. GUEST, et al.

v.

F. EMMETT FITZPATRICK, et al.

CERTIFICATE OF SERVICE.

James D. Crawford, attorney for Paul I. Guest, et al., appellants herein, and a member of the Bar of the Supreme Court of the United States, hereby certifies that on March 22, 1976 copies of the foregoing Notice of Appeal to the Supreme Court of the United States were served by hand on the several parties thereto by delivery to the offices of their respective counsel as follows:

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Dated: March 22, 1976